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THE HAMPDEN HIPPOCRAT

MARCH 1982 VOL. XXXX NO. 3

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The official bulletin for The Hampden District of The Massachusetts Medical Society. Founded in 1942 by Edward P. Bagg, Jr., M.D. and William A. R. Chapin, M.D.

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THE HAMPDEN HIPPOCRAT IS PUBLISHED MONTHLY EXCEPT FOR JULY AND AUGUST.
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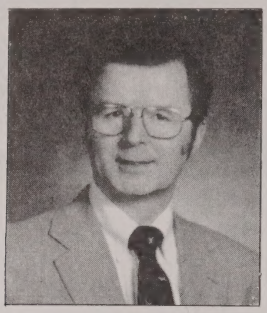

PRESIDENT'S PAGE

PHILIP B. STODDARD, M.D.
President

The Hampden District Medical Society welcomes the opportunity to recognize the contributions to our Community given by the members of the Valley District Dental Society. This issue of the Hippocrat is dedicated to our Dental Colleagues.

You will find the articles on Oral Disease, and Dentistry very informative. We physicians would do well to more carefully examine the oral cavity for signs of systemic disease!

As supporters of a good public health program we should help our dentist friends in pushing for a Fluoridation Program in Springfield. The Editorial of the Springfield Daily News, dated February 26, noted a 25% greater incidence of cavities in children in Springfield compared to the rest of the country! This is the result of public opposition to fluoridation proposals in the past. I urge you to ask your patients to support fluoridation, and to encourage better oral hygiene. It's a good road to better health.

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On March 3, 1982 the Hampden District Medical Society arranged and hosted a meeting of concerned area pediatricians and leaders of Massachusetts Medical Society, the Executive Vice President, William Munier, M.D. and Neil Foley, Director of Governmental Affairs.

Walter Pacosa, M.D., as a spokesman for the group, delineated the problems and concerns re: Medicaid, Audits, Blue Shield, and lack of effectiveness of Massachusetts Medical Society. Dr. Munier and Mr. Foley enumerated present efforts of the Society on behalf of the members in each of those areas. They were most impressive in conveying positive efforts on our behalf. They are knowledgeable, perceptive, and working hard in their jobs.

Massachusetts Medical Society has filed legislation to remove the "cap" on medicaid fees. It was successful in defeating a move permitting chiropractors to act as physicians in this state! Neil Foley is most knowledgeable on the workings of the Legislature; reviews 500 concentrates on about 100 bills filed relating to health care with the guidance of the Massachusetts Medical Society Committee on Legislation, and coordinates efforts of MMS with its lobbyist on the Hill. We may be asking for your individual help on particular bills this year. Massachusetts Medical Society has filled a bill to remove the tax exempt status of Blue Cross/Blue Shield which is stronger than the present one according to Dr. Munier.

The need for an in-house attorney is great for legal advice on day to day decisions, and the Leadership is working hard to establish that position. Hopefully the May Council meeting will approve.

This is a thumb nail sketch of the exchange of information. I believe the MMS is changing for the better.

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Valley District Dental Society

The Valley District Dental Society is delighted to have the opportunity to be contributors to your outstanding Journal. We have attempted to bring together a number of articles that I am certain will be of interest to all of you.

Medicine has made great and rapid advances in our lifetime. So, too, has dentistry. Both have so well conquered existing disease that they have been able to turn their attention to the prevention of disease. The time has come when no tooth need be lost to dental caries, when no child need have "crooked" teeth, when gum diseases (the major dental plaque of adults) can be avoided.

I am convinced that in the future we can look to the physician to assist us to a greater extent in our preventive efforts designed to reduce the dental needs of patients. Increased dietary counseling for the control of dental caries, early recognition of dental problems, fluoridation, and early referral, will be a great aid to the dental profession as a whole in meeting the challenge in the decade ahead. □

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Highlights Of The February Executive Committee

Committee met on Feruary 16, 1982.

Dr. Pacosa, Chairman of the Publications Committee was present to report on the finances of the Hampden Hippocrat. Measures will be taken to improve the situation.

The minutes of the January meeting were accepted as written.

A Letter from Dr. DiGiacomo, Chairman of the Public Health Committee was read. His suggestion of a TV program was referred to the Public Relations Committee for comment.

A Bylaw change will be suggested to the MMS to include Medical Students who are going to medical schools outside of Massachusetts.

At the March Executive meeting Dr. Vandam, President of the Boston Medical Library and Dr. Fitzpatrick, Chairman of the Committee on Education and the Library will meet to discuss the future of both libraries.

New material received from the AMA and the MMS for increasing Membership has been turned over to the Membership Committee.

The meeting was adjourned at 9:15 P.M. □

WILLIAM W. WALTHALL, M.D.
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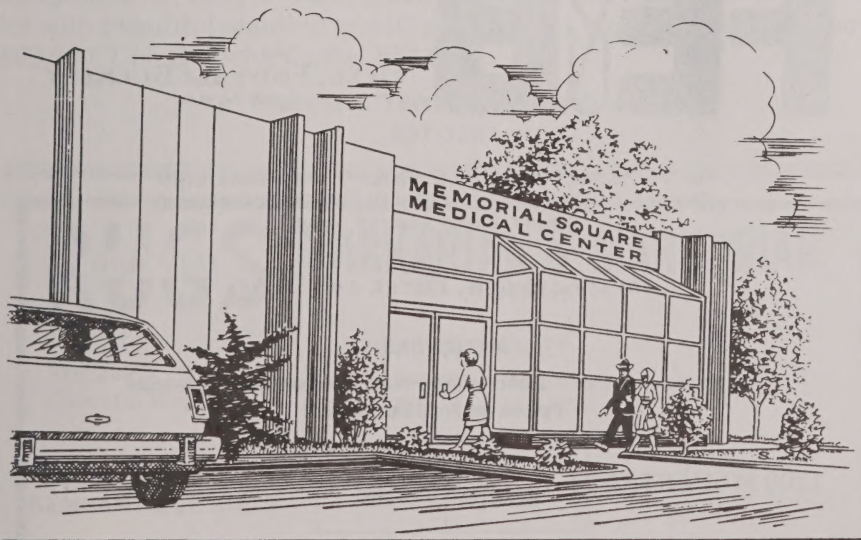

"Dental Caries A Totally Preventable Disease"

The most widespread health problem affecting today's children is dental disease. Recent dental surveys indicate that:

1. 5% of one year old and 10% of two year old children have dental decay.
2. 55% of five year olds and 75% of six year olds have caries.
3. 85% of 10 year old children and about 95% of all adults have dental disease.

According to the American Academy of Pedodontics, a professional organization representing specially trained pediatric dentists, dental disease in children is totally preventable. It is important to examine the issues involved in the cultural acceptance of such widespread disease, considering the potential personal discomfort, inconvenience and expense involved in treatment and, moreover, the fact that it is totally preventable.

Tooth decay in children is not just a whole in a tooth, but an infectious disease process. Research during the past 20 years has given us many answers to a very intricate and complicated issue. The dental

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profession has known for half a century that tooth decay is a gradual process that results from acid in contact with the tooth surface dissolving the enamel, and that this acid is produced by bacterial flora normally present in the oral cavity. Why a mouth with rampant decay and one that is caries free have similar microbiologic pictures has been a major focus of caries research. A classic study in 1960 demonstrated that innoculation of microorganisms isolated from carious rodent teeth into germ free rats who were provided with a diet rich in sucrose would initiate caries. Later, studies utilizing microorganisms isolated from human caries produced the same results. These bacteria were similar and all capable of simple sugar fermentation. When incubated with sucrose, however, all produced a very sticky substance identified as extracellular glucan. **Streptococcus Mutans** was later identified as the major bacterial entity in this process. This microorganism is unable to adhere to soft tissues or tooth surfaces easily reached by lips, tongue, cheeks and tooth cleansing devices, but adhere tenaciously to interproximal tooth surfaces and are very difficult to remove.

Streptococcus Salivarius, Streptococcus Sanguis and lactobacillus have a synergistic relationship with **Streptococcus Mutans** in the formation of smooth surface plaque. This plaque, which is a complex mixture of dense microbial elements within a gel like matrix of bacterial polysaccharides, provides an acid reservoir and concentrates fermentative activity for a prolonged period of time on the tooth surface.

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It becomes clear that if we accept the premise that dental caries is preventable, then we must address the diet as the major factor in prevention. As has been stated previously, sugar is the essential nutrient for all caries activity. It must be in close contact with the tooth surface so that it can be available as a substrate for local bacterial metabolism. Glucose, once liberated from sucrose, enters the cell of these microorganisms resulting in lactic acid production and ATP synthesis. Also, glucose may be used as a building block in long chain polysaccharide synthesis crucial to early plaque matrix development.

One must now examine the average child's diet as it relates to the caries process. Although carbohydrate is essential to the diet, it is not necessary that it be in the form of refined sugars. The average American consumes about 100 pounds of sugar every year. This is central to the discrepency between the preventability of caries and its prevalence in this country. Research has also found that other factors affect the cariogenicity of sugar. These include:

1. The form of the food - sugar containing foods in a solid sticky form has a far more profound effect on caries development than sugar containing foods in a liquid non sticky form.

2. Time of day - sugar snacks between meals have a greater effect than the same foods eaten during mealtime. Increased salivary flow and inhibitory effects of certain food types may contribute to this fact.

3. Frequency - the greatest vulnerability to tooth decay occurs 15-20 minutes after sugar is eaten, when the PH in the bacterial plaque drops precipitously. The more often sugar is consumed, the greater the incidence of caries.

In order to have a better understanding of dentistry's multifacited approach to caries prevention, one must not only examine the nutri-

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tional and microbiologic factors, but the microstructure of tooth enamel and how alterations of the oral environment can result in enamel more resistant to acid dissolution.

The enamel is an inorganic hydroxy - apetite crystal and although the appearance of clinically normal teeth is relatively constant over long periods of time, the tooth structure undergoes continuous change in both physiochemical and morphological properties as a result of constant interplay with its surrounding environment. It is important to realize that enamel is a mineralized secretory product and is subject to an equalibrium between dissolution and remineralization. In a "healthy" oral environment the balance is toward remineralization, while in a caries active mouth demineralization prevails. More accurately, caries is the end result of a series of back and forth shifts in chemical equalibrium which in summation dictate conditions more favorable to inorganic dissolution then to recrystallization.

The consumption of fluoridated water throughout life reduces the caries rate by 50 - 60%. Firstly, it reduces the acid solubility of hydroxyapetite by substituting fluoride for the hydroxyl component. Secondly, fluoride appears to favor significantly the rate of enamel remineralization and thirdly, fluoride seems to reduce bacterial activity in the dental plaque.

Topical fluoride also benefits the teeth by chemically combining with and reducing the solubility of surface enamel. Its effect, however, diminishes with time after topical fluoride is discontinued.

In summary, then, the three essentials for caries are:

1. A dietary, carbohydrate substrate, most importantly sucrose.

2. Bacteria capable of fermentation of carbohydrate to lactic acid. **Streptococcus Mutans** is the major microbiologic factor.

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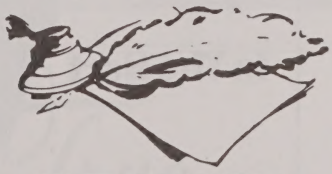

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3. Susceptable tooth structure upon which fermentative acid biproducts produce demineralization.

The pedodontist, pediatrician, and family practitioner must work together in order to educate parents to change very strong culturally dictated dietary habits. The ingestion of large amounts of refined sugars in the diet have implications that go far beyond that of dental disease. The dental caries that we accept as normal should not be tolerated during childhood. The pain and suffering of young children is inexcusable considering the preventability of dental decay.

An example that comes to mind is "nursing bottle caries." This is a rather common occurence in which young children beyond the age of six months are allowed to sleep with a bottle in their mouth. The formula, milk or juice (and in some cases, Kool Aid or soda) is slightly acidic and act to demineralize the tooth enamel, while the sugars in the liquid aid in plaque formation. The process is also enhanced by a decreased salivary flow during sleep which greatly reduces any natural buffering effect. It is not common for the pedodontist to see 18-20 month old children who require crowns on all of their teeth as a result of rampant decay.

The ultimate responsibility for the prevention of dental disease in children belongs to the parents. It is the responsibility of the dentist and physician to educate those parents so that they have the knowledge to choose intelligent alternatives. □

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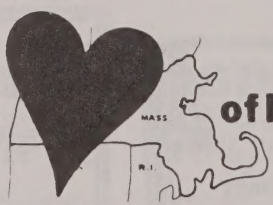

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Doctor, Why Are You Irritating Your Patients By Keeping Them Waiting?

The Mediation Committee has been handling a heavy load of complaints from patients who have been kept waiting for their physician's appointment. It is only common courtesy for both parties to an appointment to be on time, whether it is in a physicians, dentists, lawyers or other professional's office. It is a contract between two parties when an appointment is given and accepted. Not to keep that appointment indicates a complete disregard and lack of feeling for the other party.

Of course, there are extenuating circumstances when delay is unavoidable. There are emergency calls that could not be avoided or anticipated. The surgeon may be late starting or late finishing thereby arriving late at his office. This could be an occasional matter and not a frequent occurence. Where delay is uncontrollable, the patient should be notified if possible and given a later appointment when the physician can see the patient at the hour given.

I, myself, have been a victim of an hour wait (that will never happen to me again!) in a physician's waiting room, due mainly to poor scheduling and lack of concern on the part of the examining physi-

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cian. From practical experience, I can tell you first hand how it feels to wait one hour beyond the appointment time!

One can work incessantly at improving patient-physician relationship only to have them destroyed by these irritating and upsetting discourtesies.

Check your scheduling system. Don't plan to see more patients in a time space than you can effectively manage.

Don't schedule surgery in the O.R. in a time that you honestly know will keep you from being on time in the office.

Don't be habitually late in arriving at your office for the start of your hours.

Your patients will soon become upset and before long the Mediation Committee will have more work on its hands!

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Endodontics — An Overview

Even in these advanced technologic times of the 1980's there's no replacement for your natural teeth in terms of form and function. Because of this undeniable truth, and due to the concommitant improvements in anesthetic techniques and instrumentation, the role of endodontics (root canal therapy) in dentistry has grown steadily over the past five decades.

Today's modern dentist when using clinically proven and acceptable techniques can approach a 95-99% success rate in the treatment and retention of pulpally involved teeth. This is indeed a far cry from the low point of endodontics in 1910 when William Hunter, an English physician at McGill University, delivered his address on "The Role of Sepsis and Antisepsis in Medicine". At that time Dr. Hunter criticized U.S. dentistry and created a atmosphere of fear in the retention of compromised teeth (to a large degree he was really combining periodontal and periapical disease at that time).

With the advancement of modern x-ray technology, bacteriologic control, and armamentarium, the tide of extractions slowly ebbed and research studies surfaced showing teeth indeed could be saved without systemic threat. On the contrary, their successful retention could mean an improved nutritional status for a possibly compromis-

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The Physical Therapist is an important member of the medical team. For those who suffer from painful muscles and bone problems, freedom from pain is an elusive light at the end of the tunnel. Drugs may provide relief from symptoms, but they usually do not attack the cause and may become addictive. Surgery, while approprate in some cases, is too often a last resort that fails. What is a person to do?

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Working through a Physician's referral, the Physical Therapist can very often spare patients the trauma of surgery or the blank euphoria of drug dependence. For the post-operative patient, the Physical Therapist is the link in the health care team that speeds successful recovery. For the sports enthusiast, a Physical Therapist can decrease recovery time from injuries and rehabilitate the athletes for their respective activity.

If you feel Physical Therapy may help you, check with your Physician. Most health care insurances cover Physical Therapy services.

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ed patient. By the 1930 - 40's, endodontics had again been an accepted and proven clinical science.

The purpose of root canal therapy simply stated is the retention and restoration of a pulpally involved tooth to a normal functioning state in the masticatory apparatus. This includes three basic stages: 1) diagnosis, 2) instrumentation, and 3) obturation.

The diagnostic stage in any treatment must be initiated by the completion of a detailed medical history on every patient. There are many systemic conditions which may cause changes in the boney morphology and which may mimic periapical pathology due to pulpal disease. These include such entities as hyper or hypo parathyroidism, Paget's disease, hypercortisonism, osteoporosis, and localized cysts or neoplasms. For this reason often radiologic examination on its own is not sufficient to maintain a diagnosis of pulpal pathology.

Other modern diagnostic tools such as the electronic pulp tester and transillumination now augment the traditional tests of percussion, palpation observation, thermal stimulation, and others. With these additional aids it is often possible to diagnose even early stages of pulpal pathology.

However we often are still faced with those difficult cases of diffuse oral and facial pain. Pulpal pathology may mimic sinus pain, facial neuralgia, and even spread to the occipital, frontal, temporal, or other regions of the head and neck (e.g. lower molar involvement will often be described as a concomitant "ear ache").

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In the debridement phase of root canal therapy the major objectives are to remove the diseased tissue and accompanying microorganisms and to also shape and smoothen the walls of the canals to receive a root canal filling. This phase consists of both rotary and hand instrumentation segments. Rotary instrumentation, i.e. high and low speed handpieces fitted with appropriate burs, is used initially to gain access through the crown portion of the involved tooth into the pulp chamber. This is then followed by hand instrumentation.

The hand instrumentation step is probably the longest portion of the mechanical process in root canal therapy. It is chiefly accomplished by using root canal files or reamers which are composed of stainless steel. These come in carefully graded sizes and lengths and are effective in negotiating and filing the canals of a given tooth.

This filing action is usually accompanied by an irrigant, the most popular of which is a sodium hypochlorite solution. This aids in removing tissue, decreases the chances of instrument breakage, and acts to help disinfect the root canal system.

After the canals (one main canal in anterior teeth and up to four or more in posteriors) have been properly cleansed and shaped, the last step in treatment is the filling stage where an effective seal is created at the apex of the root in order to prevent future episodes of periapical pathology. The phase also has gone through an historical evolution of modes and materials.

Through the years various filling materials have been used in endodontic treatment. Silver points, paste-type preparations, and gutta percha cones have all been utilized. Today gutta percha is generally accepted as the material of choice since it is inert controllable, takes the shape of the entire canal, and gives a very predictable result (95 - 98% success rate).

Silver points although still acceptable tend to give a good seal only at the very apical portion of the canal and may not be effective for any higher lateral canals in the system. They also tend to corrode if over

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extended into an area of the body fluids. Paste fillings are general substances (such as formaldehyde, lead, or other heavy metals), and their predictability of success is difficult to assess (there is a lack of controlled studies).

The canals then are generally filled with gutta percha from the apex of the root to the pulp chamber which is contained in the clinical crown portion. The crown portion of the involved tooth may then be restored by conventional restoration dentistry procedures, such as a porcelain fused to gold crown.

Although medicaments may be sealed in the chamber portion of the root canal system between visits (there are generally 3 - 4 visits to these procedures) occasionally antibiotic therapy may also be necessary to control acute infectious processes. As in most dental infections, penicillin is still the drug of choice although with the rising incidence of allergic reactions often it is necessary to use erythromycin as a second choice (another reason to obtain a thorough medical history). Anelgesics may also be a necessary adjunct in endodontic therapy particularly in acute cases where obtaining appropriate drainage may be difficult.

In conclusion endodontics in the 1980's have evolved into an accurate controlled science which may be utilized to save the majority of pulpally involved teeth. Although there still is a small percentage of teeth which require extraction due to either an inability to treat them or a lack of supporting appartus (periodontally hopeless), the preventive thrust of modern endodontics is to minimize the incidence of partially or wholely edentulous people in our general population. This paper is designed to give a simplistic general overview of the details of this thrust. □

CHARLES HAPCOOK, D.D.S.

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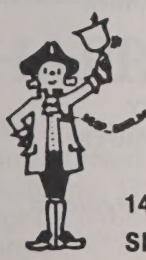

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TEETH ARE MEANT TO LAST A LIFETIME*

Many people will lose their teeth needlessly because they believe the myth that states, "It is natural to lose your teeth in the adult years." Teeth can be kept for a lifetime yet too often neglect or improper care of the mouth results in periodontal (gum) disease. This disease affects the gums, bone and other supporting structures of the teeth and even if your teeth are free of cavities, you could lose them.

An estimated 94 million people currently suffer from periodontal disease in varying degrees of severity. Although most tooth loss from periodontal disease occurs after age 35, the disease is believed to have its onset in youth. It is conservatively estimated that 62 percent of youths (ages 12-17) have gingivitis, the early reversible form of the disease, and an additional 6 percent have some teeth affected with the destructive form. Unless treated, gingivitis will eventually progress to destructive periodontitis.

The major cause of periodontal disease is bacterial plaque which is a colorless, sticky film composed primarily of normally occuring oral bacteria that forms constantly on the teeth. If this plaque is not or cannot be completely removed on a daily basis, the acids and irritants produced can destroy the gums and bones that support the teeth. The inflammation caused by the bacterial byproducts gradually destroys the connective tissue and bone surrounding the teeth leading to the formation of periodontal pockets. These pockets of unsupported gum tissue become filled with more plaque that cannot be removed by normal hygiene procedures; thus, the disease progresses. As the pockets become deeper, unremoved plaque hardens into a deposit called calculus (tarter), which is impossible to remove without profes-

* Adopted from "They're your teeth, you can keep them." American Dental Association, 1981.

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sional care. These calculus deposits make cleansing impossible since the surface is similar to that of sandpaper. Unless treated, affected teeth lose their support and become very loose, drift from their normal position and eventually are lost.

PREVENTION

Periodontal disease can be prevented only by routine plaque removal which prevents inflammation from occuring in the periodontal tissues. Toothbrushing, if done meticulously with a soft nylon toothbrush, will remove plaque from the outer, inner and chewing surfaces of the teeth. If thorough toothbrushing is carried out, only one half of the tooth surfaces will be cleaned. A sticky film of plaque also forms on the contacting sides of the teeth which cannot be removed by brushing alone, so it is imperative that dental floss be used.

Flossing should be done carefully and thoroughly everyday. It is a difficult technique to master; however, it is the best technique known for removing plaque between the teeth and under the gum line. At the present time mechanically scraping the plaque off the teeth is the only effective method of preventing periodontal disease. Hopefully, simpler and more effective methods will be discovered in the future to destroy or remove the plaque bacteria. The antiplaque drug currently being tested is chlorohexidene but this drug has been found to be ineffective if periodontal disease is already present and the side effects are numerous.

It is important to eat balanced nutritious meals to help keep the gums and supporting bone healthy. Refined sugars in the diet accelerate plaque deposition. The number of sugar exposures each day should be kept to a minimum and taken during meal times rather than between meals.

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In addition to home care and plaque removal, professional cleaning is a must. Not only are tooth deposits such as calculus and stain removed, but areas of plaque retention can be pointed out. This is very important since the patient has no way of knowing the effectiveness of his plaque removal efforts. In addition, a thorough examination should be carried out to detect the early stages of periodontal disease. An instrument called a periodontal probe is used during the examination to determine the depth of any periodontal pockets that may be present. Radiographs can also be taken to determine the presence and extent of bone destruction.

Since inflammatory periodontal disease usually progresses slowly for many years with little or no pain, most people are unaware of the problem. Periodontal disease is preventable and can be treated if discovered in the early stages. If any of the following signs or symptoms are noted, a dentist should be consulted immediately for advice and treatment:

1. Gums that bleed when the teeth are brushed.
2. Persistant bad breath and/or foul taste.
3. Soft, swollen or tender gums.
4. Pus between the gums and teeth.
5. Loose teeth.
6. Any change in the spaces between the teeth or in the way the teeth bite together.
7. Gums that have receded or pulled away from the teeth.
8. Any change in the way a partial denture fits.

SECOND FACTORS IN PERIODONTAL DISEASE

The fact that bacterial plaque is the primary causitive factor in periodontal disease has already been discussed, but other factors can contribute to or "compound" this inflammatory disease. A number of systemic conditions can contribute to the development of periodontal disease. For example, diabetes mellitus lowers the resistance of the tissues to the destructive effects of plaque. Puberty and pregnancy are often blamed for periodontal disease; however, these conditions only exaggerate an existing inflammatory condition because of the hor-

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mone inbalances that are present during these periods. Although treatment and control of systemic disorders are vital, it is obvious that daily plaque removal is still the key to periodontal health regardless of existing systemic problems.

Harmful habits such as bruxism (grinding the teeth) and nail biting can contribute to the loss of supporting bone around the teeth. In addition, abnormal forces placed on the teeth due to malocclusions, high restorations and ill-fitting bridges or partial dentures can also result in accellerated bone destruction. One may be totally unaware of such problems, including clenching or grinding habits and these conditions must be diagnosed by a dentist.

Physical irritants in the mouth can also cause injury to the supporting tissues. These irritants are too numerous to mention; however, examples would include food that becomes impacted between the teeth due to loose tooth contacts, worn out fillings which create plaque traps, and improper use of dental floss, toothbrush and toothpicks. Local irritants such as the use of tobacco also result in additional inflammation of the periodontal tissues.

Finally, some medications can effect the health of the periodontal structures. One example is Dilantin which is a commonly used anticonvulsant. This drug sensitizes the gingival tissues to irritation and may cause a gingival hyperplasia. When the overgrowth of tissue becomes severe, plaque removal is virtually impossible and so destructive inflammatory periodontal disease is accellerated. The dentist should be quite familiar with any of the common drugs that contribute to periodontal problems. Obviously the medication cannot be discontinued but steps can be taken to counteract the ill effects on the periodontal tissues.

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TREATMENT

The severity of the disease will determine the type of treatment required; however, the first step in any treatment plan is daily plaque removal. Often the removal of calculus and smoothing of the root surfaces (scaling and root planning) may be the only professional treatment required. Curettage may also be performed to remove the infected tissue lining the periodontal pockets so the periodontal tissues can heal quickly.

Often surgical therapy is necessary to restore and improve the periodontal health. A deep pocket becomes a sight of infection which leads to bone destruction and this pocket must be surgically eliminated. In each type of surgery performed, the gum and/or bone are altered to remove the pocket and provide contours that are cleansable and more resistant to disease.

When the bone has not been destroyed but soft tissue pockets are present, a gingivectomy may be required. This technique removes the unsupported periodontal pocket and allows the gums to reattach to the tooth. In addition, the tissue is reshaped to create a new functional form that allows for adequate plaque removal.

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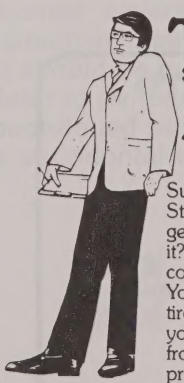
When pockets are deep and the bone has been involved, flap surgery is usually necessary. The gum is lifted away from the tooth and underlying bone, and the diseased tissue lining the periodontal pocket is removed. Often this procedure is accompanied by osseous surgery when bony defects are present. The bone surrounding the tooth is either reshaped or part of it is removed to help eliminate the deformity. Occasionally, bone regeneration procedures are carried out by attempting osseous grafting procedures. The gum is then sutured back into place or into a new position.

A relatively new procedure that has proven to be quite successful in certain cases is that of a free gingival graft. This procedure consists of taking a section of firm gum tissue, usually from the roof of the mouth, and grafting it in an area where the firm protective attached-type gum has been lost. This is very commonly used in areas of high muscle attachment where the gum is being stripped away from the tooth. The procedure is very predictable and effective, and may be used on children to prevent stripping away of the gum that is seen in later life.



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Other types of treatment may be required to eliminate factors that contribute to the development of periodontal disease. When abnormal chewing or biting forces are present, the dentist may need to change the way the teeth occlude to avoid the destructive forces applied to the supporting tissues. If missing teeth are present, they must be replaced to prevent further shifting of the dentition. In addition, orthodontic therapy may be required to reposition teeth and selective reshaping of certain teeth may be necessary to properly distribute the occlusal forces. Splints or other appliances may be required to stabilize loose teeth or to decrease the effects of trauma caused by bruxism.

Unfortunately modern dentistry is quite limited in its ability to regenerate lost supporting tissue, including the bony support. Thus it is obvious that early diagnosis and treatment are the key to maintaining teeth for a lifetime. The vast majority of periodontal patients are unaware of their disease until they are informed by their dentists. Nine out of ten adult Americans suffer from some level of periodontal disease and many will lose their teeth unnecessarily. □

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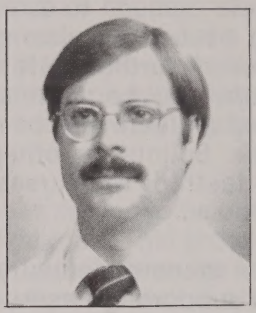
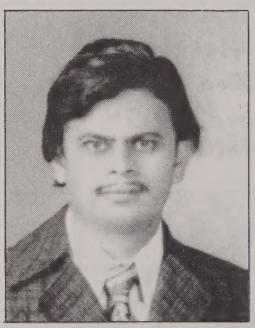


Paul T. von Oeyen, M.D.
759 Chestnut St.
Springfield, MA 01107

BORN:	July 26, 1949
PREMED:	Brown University 1967-71
MEDICAL SCHOOL:	Brown University 1971-75
INTERNSHIP:	New York Hospital-Cornell Medical Center 1/75-6/75
RESIDENCY:	New York Hospital-Cornell Medical Center 1975-79
FELLOWSHIP:	Brigham & Women's Hospital-Harvard Medical School in Maternal-Fetal Medicine 7/79-6/81
SPECIALTY:	OBSTETRICS & GYNECOLOGY



Dilipkumar S. Vagal, M.D.
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BORN:	October 4, 1946
PREMED:	Parle College, Bombay India 1962-64
	L.T. Municipal Medical College 1964-70
MEDICAL SCHOOL:	L.T. Municipal General Hospital 1970-73
INTERNSHIP:	University of Connecticut 1976-77
RESIDENCY:	University of Connecticut 1977-79
FELLOWSHIP:	St. Francis Hospital in Ambulatory Pediatrics 1979-80
SPECIALTY:	PEDIATRICS

Dear Members of the Auxiliary,

On behalf of the Science Museum, I would like to thank you for your recent check for $205.50 for the purchase of films and educational materials for the new health education kit. This kit will be a marvelous supplement to classroom teaching and will provide the children with an exciting "hands-on" approach to good health.

I would also like to take this opportunity to thank the members of the Auxiliary for the tremendous amount of time and energy they have given to the museum this past year. The teachers of the "Wonderful You" health program have all been excellent and have made the program a very popular offering. We also appreciate all the time some of your members have contributed to developing the new health kit.

The prospects for the new Health Hall are looking very bright. The museum's Unit Committee has given Mr. Ives the go-ahead to update the preliminary plans for the hall, and the Quadrangle's Development Office is currently checking with federal agencies on available funding for such projects. We are somewhat distressed by the recent "Reaganomics" but are pursuing all possible sources, including private foundations, for funding. I'll keep you posted on all activities. Your group's continued interest and financial support for Health Hall have been a positive force in many recent decisions.

Thank you once again. Please feel free to call me at any time if I can answer questions or provide information.

Sincerely,
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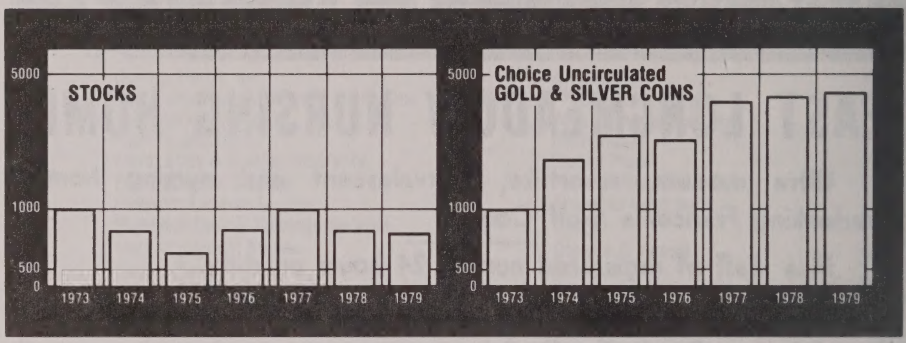

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